Central East **LHIN**

Making A Difference

Engaged Communities. Healthy Communities.

Central East LHIN 2009-10 Annual Report

00,000 Hours - Save 10,000 Days
Statement of Intent
We, health service providers, health care professionals and clients within the Central East LHIN are committed to leading an integrated sustainable health care system that ensures better health, better care and better value.
Working in collaboration and by raising our aspirations, we are committed to making measurable improvements to achieve the Strategic Aims.
10%

Ontario
Local Health Integration Network

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK (9)

The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs). LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas. LHINs received funding authority and the funding responsibility for their providers on April 1, 2007. This is the third Annual Report for the LHINs with their full authorities.

For more information about LHINs, including frequently asked questions, visit the LHINs' web site at www.lhins.on.ca

Table of Contents

MESSAGE FROM OUR CHAIR AND CEO 2

MEMBERS OF THE BOARD 3

INTRODUCTION 4

MINISTRY/LHIN ACCOUNTABILITY AGREEMENT (MLAA) 5

What is an MLAA? 5

MLAA Performance Indicators 5

Central East LHIN Integrated Health Service Plan (IHSP) 9

Implementation of the IHSP 9

Community Engagement Activities 15

Francophone Initiatives 15

Aboriginal Initiatives 16

Integration Activities 20

ER Wait Times Initiatives/ Improving the ALC Situation 22

ANALYSIS OF CE LHIN OPERATIONAL PERFORMANCE 24

AUDITORS' REPORT 25

Statement of Financial Position 26

Statement of Financial Activities 27

Statement of Changes in Net Debt 28

Statement of Cash Flows 28

Notes to Financial Statements 29

STAFF MEMBERS 36

CONTACT INFORMATION 37

MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report – "Making A Difference" – takes its title from the LHIN's May 2009 Symposium and once again serves as a testament to the dedication of health care service providers, community leaders, patients, clients, consumers and their families who have stepped forward to transform the health care system.

In 2009/10 the Central East LHIN began moving the health care system from discussions around planning to the implementation and achievement of measurable projects aligned with the LHIN's accountability agreement with the Ministry of Health and Long-Term Care. Through collaboration, innovation and integration, a strategy was developed and activated that began co-ordinating the system to achieve common goals that would lead to optimal outcomes for patients, providers and the system.

System goals which were articulated by the government – improve access to emergency department care by reducing the amount of time that patients spend waiting in the emergency department, improve access to hospital care by reducing the amount of time that patients spend in alternate level of care beds and improve access to integrated diabetes care – became the rallying challenge and guided the development of the Central East LHIN's 2010-2013 Integrated Health Service Plan (IHSP).

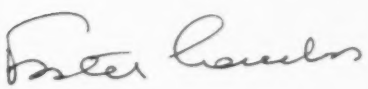
Using the Institute for Healthcare Improvement's Triple Aim framework, the LHIN began working with health service providers on projects that strived to improve the health of the population, enhance the patient care experience and reduce, or at least control, the per capita cost of care – all at the same time.

The value of Triple Aim was that it sharpened the focus of the LHIN and its health service providers, provided an inclusive framework that brought stakeholders to a common focus, it helped to prevent a potential perverse outcome of an unbalanced approach to hospital challenges and provided a value proposition to the community.

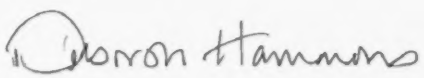
In early May the LHIN shared two potential goals with the LHIN community – Save 1,000,000 hours spent by patients in hospital Emergency Departments by 2013 and reduce the impact of Vascular Disease by 10% by 2013.

This Annual Report outlines how, in 2009/10, the LHIN sought consensus on these goals from both health service providers and the broader community while at the same time aligning all its activities to meet its accountability obligations to the Ministry of Health and Long-Term Care.

As always we would like to thank the hundreds of health service providers – doctors, nurses, allied health, support staff, administrators and volunteers – who dedicate themselves to their patients, clients, consumers and their families. They are the reason the LHIN was "Making a Difference" in 2009/10.



Foster Loucks,
Chair



Deborah Hammons,
CEO

MEMBERS OF THE BOARD

Foster Loucks	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: April 1, 2008 – June 1, 2011
Joseline Sikorski	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: April 1, 2008 – June 1, 2011
Jean Achmatowicz MacLeod	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: April 1, 2008 – June 1, 2011
Novina Wong	Term of Office: January 5, 2006 – February 4, 2007 Reappointed: February 5, 2007 – February 4, 2010 Resigned: September 1, 2009
Stephen Kylie	Term of Office: March 1, 2006 – February 29, 2008 Reappointed: March 1, 2008 – February 28, 2011
Dr. Alexander Hukowich	Term of Office: May 17, 2006 – June 16, 2007 Reappointed: June 17, 2007 – June 16, 2010
William Gleed	Term of Office: May 17, 2006 – June 16, 2007 Reappointed: June 17, 2007 – June 16, 2010
Ronald Francis	Term of Office: May 17, 2006 – May 16, 2008 Reappointed: May 17, 2008 – May 16, 2011
David Nichols	Term of Office: February 17, 2010 – February 16, 2013

The governance structure for the LHINs is set out in the Local Health System Integration Act, 2006. LHINs operate as not-for-profit organizations governed by a board of directors appointed by the province.

Each LHIN has a maximum of nine board members appointed by the Lieutenant Governor in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Lieutenant Governor in Council is responsible for designating the Chair and at least one Vice-Chair from among the members.

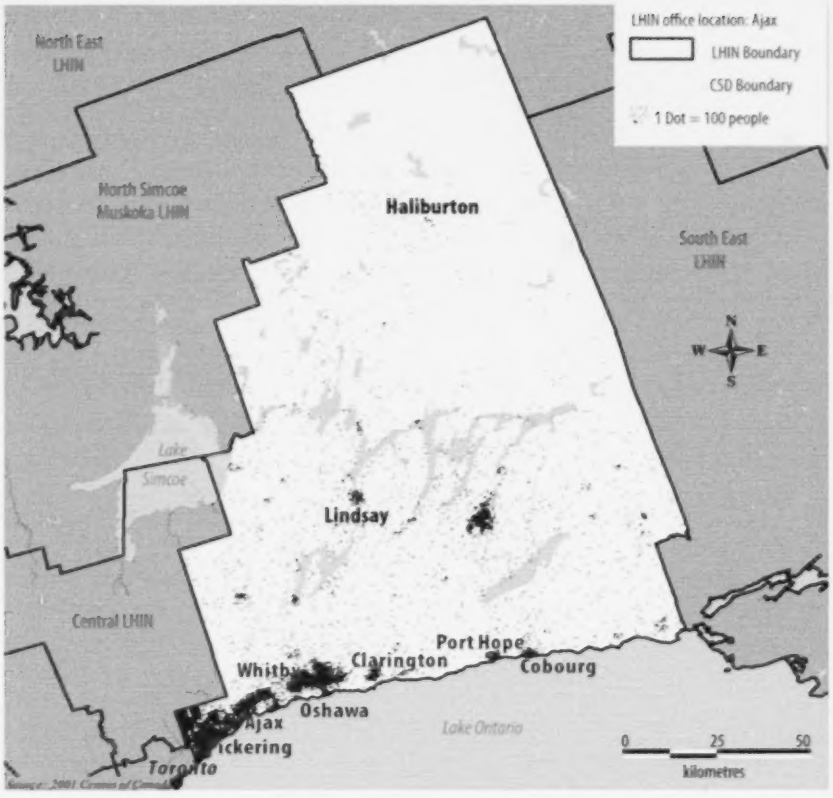
The board of directors is responsible for the management and control of the affairs of the LHIN and is the key point of interaction with the Ministry. The board may pass by-laws and resolutions and may establish committees. Certain by-laws may require the Minister's approval. Details on the Central East Board of Directors can be found on the Central East LHIN web site at: http://www.centraleastlhin.on.ca.

INTRODUCTION

The Central East LHIN is one of 14 Local Health Integration Networks that have been established by the Government of Ontario as community-based organizations to plan, co-ordinate, integrate and fund health care services at the local level including hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services and community health centres.

The Central East LHIN is one of the fastest growing geographic regions in the province and home to approximately 11% of Ontario's population. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park!

Population Map



Source: MOHLTC Health Analytics Branch

The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

	CENTRAL EAST	ONTARIO	LHIN Range
Total population (2006)†	**1,484,300**	**12,687,000**	**238,000 - 1,604,900**
Senior population, age 65+ (2006)†	13.2%	12.9%	9.0 - 16.7%
Population with English mother tongue	74.5%	71.9%	55.7 - 92.2%
Population with French mother tongue	1.5%	4.7%	1.2 - 25.1%
Population who are immigrants	32.0%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996-2001)	5.7%	4.8%	0.3 - 9.7%
Population who are visible minorities	30.2%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	0.9%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	66.3%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	6.7%	6.1%	5.0 - 9.8%
Population in low income	14.8%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	24.4%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	7.7%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	26.5%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	46.2%	48.7%	42.4 - 55.8%

Source: †2006 Population estimates, MOHLTC Provincial Health Planning Database. Remaining indicators based on 2001 Census of Canada.

MINISTRY/LHIN ACCOUNTABILITY AGREEMENT (MLAA)

What is an MLAA?

The Central East Local Health Integration Network (CE LHIN) and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed an accountability agreement which defines the obligations and responsibilities of both the LHIN and the Ministry for the period 2007/08 to 2009/10. The Ministry/LHIN Accountability Agreement (MLAA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and eHealth.

The MLAA is mirrored in the Accountability Agreements that LHINs have already negotiated with some health service providers.

MLAA Performance Indicators

The *Ministry-LHIN Accountability Agreement* clearly defines the relationship between the Ministry of Health and Long-Term Care and the CE LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines respective performance targets within a pre-defined period of time. The following table outlines CE LHIN performance against targets for 2009/10.

Central East LHIN MLAA Performance Indicators 2009/10

Performance Indicator	LHIN Starting Point 09/10	LHIN Performance Target – 09 /10	Most Recent Quarter 2009/10 LHIN Performance	FY 09/10	LHIN Met Target - Within Corridor (YES/NO)
1. 90th Percentile Wait Times for Cancer Surgery	**51**	48	51	**49**	**YES**
2. 90th Percentile Wait Times for Cataract Surgery	**140**	140	125	**127**	**YES**
3. 90th Percentile Wait Times for Hip Replacement	**184**	182	188	**173**	**YES**
4. 90th Percentile Wait Times for Knee Replacement	**188**	182	174	**171**	**YES**
5. 90th Percentile Wait Times for Diagnostic MRI Scan	**83**	65	107	**107**	**NO**
6. 90th Percentile Wait Times for Diagnostic CT Scan	**32**	28	44	**41**	**NO**
7. Median Wait Time to Long-Term Care Home Placement -All Placements	**86**	75	126	**114**	**NO**
8. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	**15.26%**	9.46%	18.11%	**18.16%**	**NO**
9. Proportion of Admitted patients treated within the LOS target of ≤ 8 hours	**32.00%**	39.00%	29.89%	**31.24%**	**NO**
10. Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III	**83.00%**	89.00%	83.36%	**83.74%**	**NO**
11. Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours	**81.00%**	87.00%	82.15%	**81.42%**	**NO**

Note: **The success of CE LHIN in meeting performance targets for each MLAA indicator is assessed taking into account an upper limit performance corridor (i.e. performance target + X%).**
***Performance indicators 1-7 = Q4 2008/09; and 8-11 = Q3 2008/09**
****Performance indicators 8-11 (in the Annual Results Column) only include the average of Q1-3**

At the end of 2009/10, the Central East LHIN was able to **achieve four performance targets** identified in its MLAA. A description of these four targets and an explanation for the achievements follows:

Performance Indicator #1
90th Percentile Wait Times for Cancer Surgery
In 2009/10, the LHIN's performance related to this indicator has been well below the provincial target. The arrival of two new surgeons at The Scarborough Hospital and three new surgeons at Rouge Valley Health System has positively impacted wait times in these communities.

Performance Indicator #2
90th Percentile Wait Times for Cataract Surgery
Hospitals from across the LHIN contributed to the performance measured by this indicator with all completing their funded volumes and some indicating that they have the resources to provide additional procedures. Through the LHIN's Wait Time Allocation group, which includes representatives from all CE LHIN hospitals, the LHIN will be working with providers to reallocate procedures to lower volume centres in order to further improve wait times. A review of steps related to Cataract Surgery, using LEAN methodology is also helping to improve patient care delivery.

Performance Indicator #3
90th Percentile Wait Times for Hip Replacement
Throughout the fiscal year, CE LHIN wait time performance for hip replacements has been below both the CE LHIN and Provincial Target with a temporary increase in Q3. Most CE LHIN hospitals have been below target wait times. Challenges experienced by Rouge Valley Health System, Lakeridge Health and Ross Memorial Hospital related to physician availability and physical plant were being resolved in 2009/10 through partnerships with other CE LHIN hospitals. Referral patterns are being refined to ensure that specialists are being appropriately accessed.

Performance Indicator #4
90th Percentile Wait Times for Knee Replacement
Similar to hip replacement – see above.

At the end of 2009/10, the Central East LHIN was **unable to achieve seven performance targets** identified in its MLAA. A description of these seven targets and an explanation for the variance follows:

Performance Indicator #5
90th Percentile Wait Times for Diagnostic MRI Scan
Central East LHIN meets every month with all its hospitals to discuss issues and their subsequent resolution. This includes current YTD wait lists for each hospital, identification of capacity versus need, patient need, referral patterns and capital requirements.

In 2009/10 all CE LHIN hospitals were below both the CE LHIN and Provincial Target with the exception of The Scarborough Hospital and Rouge Valley Health System – Centenary Site. Initiatives to improve performance include involvement in the provincial Process Improvement Process (PIP) which is intended to assist in the reduction of MRI wait times; the future installation of an MRI at Ross Memorial Hospital (January 2011); reallocation of funded volumes to other sites in the LHIN; identification of sites for new MRIs; and, improved referral patterns with family physicians. System monitoring with the LHIN's Diagnostic Imaging Directors' Group and the Wait Time Strategy Working Group are ongoing and best practice initiatives are continuing to be implemented.

Performance Indicator #6
90th Percentile Wait Times for CT Scan
Aging equipment and increasing complexity of cases is having a negative impact on the ability of CE LHIN hospitals to meet this performance indicator. Despite individual achievements by specific hospitals, the combined measurement reflects scans that are taking longer to complete due to complexity, aging machines and increased referrals from local physicians and the hospitals' Emergency Departments. An in-year reallocation of surplus funds from other sectors allowed for an additional 2,707 hours to be provided to four hospitals. The LHIN is continuing to monitor and resolve the situation.

Performance Indicator #7
Median Wait Time for Long-Term Care Home Placement
The LHIN continues to face challenges in meeting this performance indicator given that improvement involves a longer term strategy and provincial direction that will impact all LHINs.

With the second highest senior population (>75 years) in the province, the LHIN was successful in having the highest number of clients placed in February 2010, but other factors continue to contribute to longer than anticipated wait times, including:

- Socio-demographic nature of residents within LHIN boundaries
- Personal choice as per legislation
- Cultural preferences for various LTC Homes
- Hard to serve populations (e.g. psycho-geriatric patients)
- Availability of beds related to demand preference
- Resources available at the CE CCAC to support placement

Notwithstanding these problems, the LHIN creatively explored alternative solutions through the provincial Aging at Home and Emergency Department/Alternate Level of Care strategies. Discussions with the Long-Term Care sector are also helping to identify options and alternate strategies to deal with ongoing pressures.

Performance Indicator #8
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:
The CE LHIN did not achieve the provincial goal of 9.46% ALC in the 2009-10 fiscal year. The new provincial ALC definition, imposed in July of 2009, while it helped create consistency across the LHIN and across the province, also resulted in a spike in ALC numbers, with the LHIN's performance for the year reaching 18.16%. Much of the planning for 2010-11 involves addressing patient flow through the system and decreasing ALC.

Performance Indicator #9
Proportion of Admitted patients treated within the LOS target of equal to/less than 8 hours
The CE LHIN, like the province, experiences challenges in addressing this indicator. The 90th percentile average for the LHIN is 47.81 hours, and the median is 47.65 hours, compared to 30.54 hours and 31.13 for the province, respectively. For the percent within target indicator, the LHIN's performance has improved, from a baseline of 32% to an average of 31.24%, and a median of 31%. This measure is related to percentage ALC, and is being targeted by several initiatives for the 2010-11 fiscal year.

Performance Indicator #10
Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of equal to/less than 8 hours for CTAS I-II and equal to/less than 6 hours for CTAS III.
Despite non-achievement of the target set in the MLAA, the LHIN was pleased that performance improved in this indicator from an already high baseline of 83% of patients treated within target to an average of 83.74%, and a median of 84%. Joint efforts with health service providers will continue in 2010/11 to meet ongoing targets.

Performance Indicator #11

Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of equal to/less than 4 hours

Despite non-achievement of the target set in the MLAA, the LHIN was pleased that performance improved in this indicator from a high baseline of 81% of patients treated within target to an average of 81.42%, and a median of 82%. The 90th percentile average length of stay for these patients is 5.04 hours, and the median is 5.01 hours. Many initiatives were in place in 2009/10 and will continue through the next two years to address this indicator, including both initiatives directed at shortening length of stay for ED visits, and providing appropriate care alternatives for these low-acuity patients..

Central East LHIN Integrated Health Service Plan (IHSP)

In November 2006, when the Central East LHIN released its Integrated Health Service Plan, it stated that "this initial Integrated Health Service Plan is focused on system design with a focus on key health care priorities for change." The Plan provided "upstream" strategies – such as disease prevention and management, housing, cultural competency - which will reduce unnecessary use of limited and more expensive health care services "downstream."

Implementation of the IHSP

In 2009/10, health service providers, patients and stakeholders from across the region continued to work on completing projects related to the implementation of the 2007–2010 Integrated Health Service Plan (IHSP) and began planning for the 2010-2013 IHSP. In the 2007-2010 IHSP, 117 goals were identified and of those 94% were either completed, linked to another initiative or project or are continuing into 2010-2011. Of the thirty four priority projects implemented as part of the first IHSP, 53% were conducted as projects and produced deliverables within scope, on time and on budget, 20% of the recommendations are being managed through projects currently in process and an additional 13% of the recommendations were achieved either through linkages to other projects, initiatives or managed as a process.

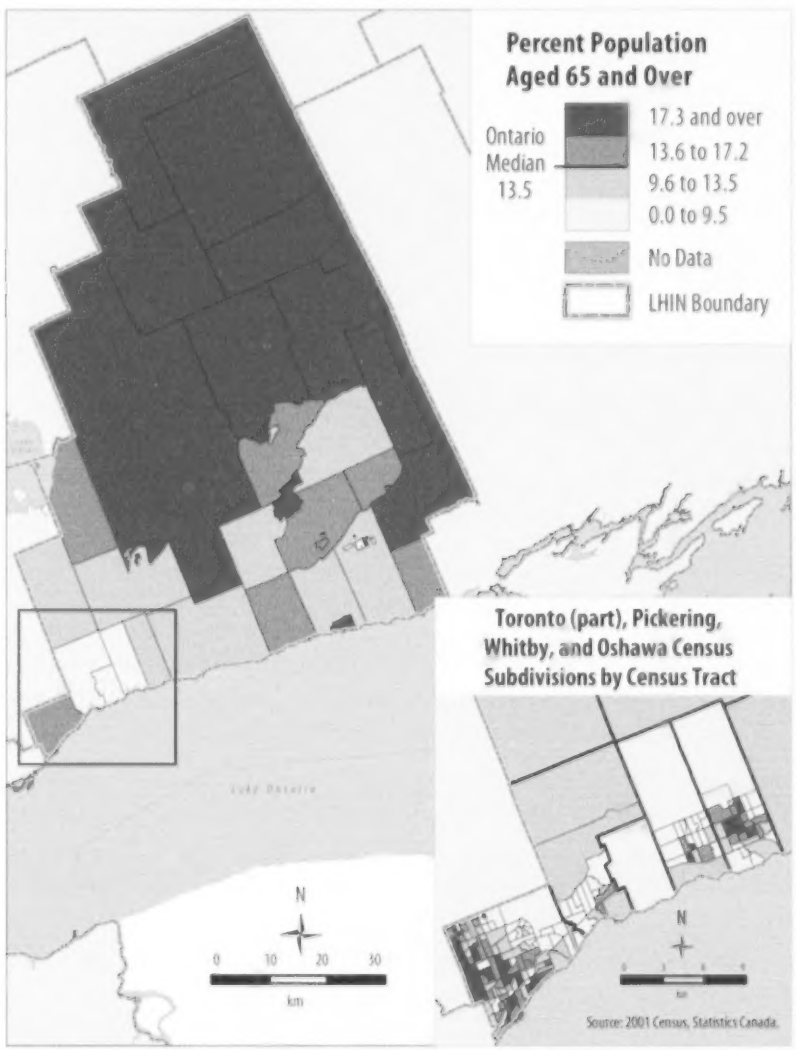
Projects in the 2007-2010 IHSP specifically benefited identified populations in three priority areas – Seamless Care for Seniors; Chronic Disease Prevention and Management; and Mental Health and Addictions.

Seamless Care for Seniors

Seamless Care for Seniors' Framework - completed

- *The Planning Framework for Seamless Care for Seniors within the Central East LHIN* was developed by the Central East LHIN Seamless Care for Seniors Network and contained a Vision, a Mission statement, Guiding Principles, Planning Pillars and Enablers. The framework acted as a guideline for providers, consumers and LHIN staff and Board, as they collectively planned and implemented a seamless system of care and supports for seniors.

Percent Population Aged 65 and over



Source: MOHLTC Health Analytics Branch

Proposals funded through the Provincial Aging at Home Strategy – announced May 2009

- Funding was announced for twenty-one (21) projects in fours key areas including Transportation Services; Caregiver Support Services; Supportive Housing; and Specialized Geriatric Services to allow seniors to live healthy, independent lives in the comfort and dignity of their own homes.

Supportive Housing Priority Project Report – completed

- To better understand the role that supportive housing plays in the continuum of care and further, to assist in determining future investment opportunities in Central East, a Project Team researched, explored and recommended leading practices/approaches to supportive housing and initiated development of a fair, transparent and supportable basis for determining where supportive housing should be available/enhanced in Central East.
  (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22e9a_72_206_94_2)

Community Support Services (CSS) Review Priority Project Report – completed

- To bolster the CSS sector's sustainability as a more equitable component of the health and support system across Central East, a Project Team assessed current CSS infrastructure and resources, recommended where to invest in CSS sector, identified barriers and innovative opportunities in the CSS sector, recommended strategies for enhancing integration and began to identify the appropriate human resources (paid and volunteer) required to sustain and grow the CSS sector responsibly.
  (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22e9a_72_206_94_2)

Caregiver Supports and Well-being Priority Project Report – completed

- In recognition that Caregivers are an essential part of the health care continuum, this project's purpose was to ensure that caregivers are provided the right support, at the right time, in the right place. The project's aim was to support caregivers more effectively and to build the capacity of individuals and families to be caregivers. The Project Team acknowledged and validated issues and needs specific to caregivers. The project identified best practices and opportunities for integration of caregiver supports through examination of what exists and what is not currently in place. The project delineated the system of caregiver support required for the Central East LHIN.
  (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22e9a_72_206_94_2)

Home at Last (HAL) Priority Project – ongoing

- While there may come a time in everyone's life when they will require the services offered in a hospital setting, most people are glad to return to their own homes as quickly as possible to heal and recuperate. This issue becomes pronounced in the aging population as seniors remaining longer than necessary in an acute care environment can cause more harm than good. The Project Team designed and delivered a plan for rolling out the HAL program at all CE LHIN hospital sites and by March 31, 2010 the program had provided over 1,365 settlements in helping people to return home. (http://www.centraleastlhin.on.ca/Page.aspx?id=10252)

Rehabilitation - completed

- The primary goal of the rehabilitation project was to produce a guiding document to outline a shared philosophy and principles of rehabilitation care delivery, embodied in patient and family-centered care. In addition, the document reviewed and consolidated individual, current strategy documents that related to rehab service delivery and offered potential opportunities for efficiencies and system sustainability. The second goal of the project was to create a common, shared understanding of rehabilitation definitions and population groups.
- Thirty-seven recommendations were made in the report and the Rehabilitation Task Group acknowledged that the next steps and the achievement of many of the strategies and recommendations outlined in the report will require an ongoing commitment to work in partnership with many of the other LHIN Networks, Committees,

Collaboratives and Task Groups. Rehabilitation is an "enabler" for the system, and must be a critical component of new initiatives focused on improving the health of the communities served by the LHIN. (http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Board_of_Directors/Board_Meeting_Submenu/REHAB_REPORT_-_Final.pdf)

GEM: Pursue Enhancement of Geriatric Expertise in Hospital Emergency Departments - ongoing

- The role of the Geriatric Emergency Management (GEM) Nurse is to deliver targeted geriatric assessments to high-risk seniors in the ED and to build capacity through knowledge transfer among ED staff and other health care partners (Regional Geriatric Program, 2009).
- To build geriatric expertise within the Central East LHIN, 9 GEM nurse positions were funded and implemented in Central East LHIN hospitals as part of the 2007-10 IHSP.

Chronic Disease Prevention and Management

Lakeridge Health Oshawa designated as a District Stroke Centre – ongoing

- In November 2008, the Central East LHIN, with the support of the Ontario Stroke Network, designated Lakeridge Health Oshawa as a District Stroke Centre. Funding received with the designation allowed the hospital to hire specialized clinical staff and purchase clot busting drugs, commonly called t-PA, which can be quickly administered to minimize the effects of a stroke. Lakeridge Health partnered with the existing District Stroke Centre at the Peterborough Regional Health Centre to begin building a unified Stroke System in the Central East LHIN. The designation means close to home care for Durham Region stroke patients who previously had to travel to Toronto, Barrie, York Region or Peterborough to access these services.

Early Identification, Intervention and Integration of Chronic Disease Prevention & Management (CDPM) within the Chronic Kidney Disease (CKD) population in the Central East Local Health Integration Network (CE LHIN) – ongoing

- The goal of this initiative was for all three Regional Renal program partners in the Central East LHIN to come together and jointly develop and implement a sustainable CKD Chronic Disease Prevention and Management (CDPM) model for the Central East LHIN, a model that could be replicated as a whole or in parts across other LHINs (including other chronic disease specific models). The model was intended to meet the needs of the renal health care providers, current CKD patients and those at risk for CKD. This project focused across the care continuum, including early identification of those at risk for CKD, delaying the progression to end stage renal disease (ESRD), decreasing the need for acute and chronic dialysis, the movement to home modalities, and the principles of increased self management in chronic disease management.
- Screening in the Scarborough area included outreach to 31 agencies serving immigrant groups across 71 locations. Services were provided to groups in more than 13 languages. A total of 129 screening clinics were held and 3747 patients were screened with 35% demonstrating risk factors for CKD. In the Northeast cluster of the LHIN, more than 550 First Nations individuals were screened and 46% were identified at risk for CKD and referred for follow-up.
- The project has produced two documents to guide further improvements in CKD and chronic disease care in Central East LHIN and the province. The Promising Practices Report and the Practitioners Guide will soon be available through the Central East LHIN website. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=13042)

Self Management for Consumers/Caregivers Priority Project – ongoing

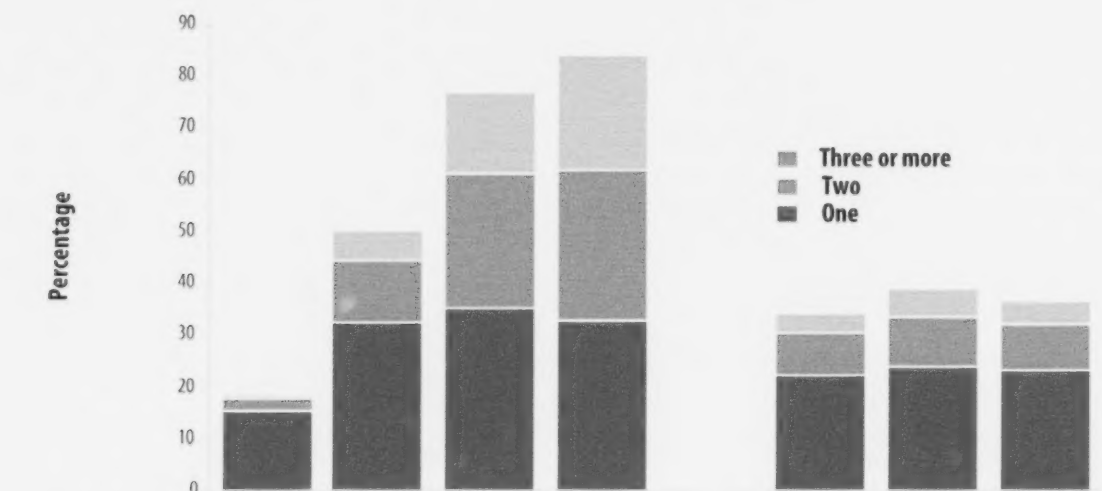
- The Chronic Disease Self-Management Model (CDSM) was introduced as the standard for Central East LHIN and was delivered across community and health care settings. The Central East Self-Management project trained 206 Peer Leaders and 37 Master Trainers as well as provided the Stanford (CDSM) program to over 1435 consumers and caregivers across the Central East region through over 112 workshops. The project is scheduled to be transitioned to a permanent program under the auspices of the Central East Community Care Access Centre in early 2010/11.

- The vision of the on-going Self-Management program is to provide a single, consistent and coordinated self-management program across the Central East LHIN. It is believed this program optimally, should encompass coordinated delivery of peer-led Stanford CDSM workshops, as well as training to health service providers in self management support and other leading edge self management-related activities which would advance the Chronic Disease Prevention and Management Framework to improve health population outcomes. (www.healthylifeworkshop.ca).

Prevention and Management of Diabetes in the Central East LHIN - ongoing

- Diabetes 2008 Clinical Practice Guidelines Rollout Priority Project - The Project Team developed and distributed 16,000 copies of a Diabetes Resource Guide entitled *"Living with Diabetes – What you should know"* to increase the profile of diabetes, diabetes services and implementation of the 2008 Clinical Practice Guidelines. The Project Team also worked to enhance coordination amongst diabetes stakeholders and ensure a consistency of practice across the CE LHIN by hosting a number of knowledge sharing events for clinicians and diabetes educators. In 2009/10 work began to translate the guide into French, Tamil and Cantonese. (http://www.centraleastlhin.on.ca/Page.aspx?id=10472)
- Diabetes Indicators Project - This pilot project introduced similar biophysical and behavioural screening indicators into diabetes education settings. The intent of the pilot was to learn from application of a consistent electronic screening tool as well as promote learnings across agencies with regard to challenges and opportunities in diabetic screening and care management. Four Diabetes Education Centres across the LHIN were involved in this project.

Population aged 12+ reporting one, two or three or more of selected chronic conditions, by age groups and sex, Ontario, 2005.



	12-44	45-64	65-74	75 +	Male	Female	Total
Three +	0.5	5.8	15.9	22.2	3.9	5.3	4.6
Two	2.6	11.8	25.9	29.1	8.1	9.6	8.9
One	15.0	32.2	35.0	32.6	21.9	23.7	22.8
	Age group				Sex		

Source: 2005 Canadian Community Health Survey, Statistics Canada, Ontario Share File.

Identify strategies to provide access to "Primary Care" to those with no doctor - completed

- The Unattached Patient Health Assessment and Referral Centre (UPA) was created to provide people without access to a regular primary health care provider (an unattached patient) with access to screening for risk, assessment for disease and as needed, referral/triage to existing community health and/or specialist resources. This new service helped individuals understand their health conditions and get access to the care they need to manage their health. The service was not considered a replacement for on-going comprehensive primary care. In partnership with the CCAC Health Care Connect program, referral to a permanent primary care provider was facilitated for many patients.
- The first Unattached Patient Health Assessment and Referral Centre Clinic opened in Bethany in September 2009 with expansion to Bobcaygeon, Peterborough Clinic, Peterborough Youth Emergency Shelter, Rouge Valley Centenary, West Hill Community Health Centre and the Scarborough Academic Family Health Team. Results found that more than 30% of patients seen by UPA in rural areas had previously undiagnosed pathology which includes diabetes, dyslipidemia, COPD, cardiovascular disease, melanoma, metabolic syndrome, osteoporosis and hypertension.

Mental Health and Addictions

Addiction Environmental Scan - completed

- The environmental scan was to assist addiction service providers in the CE LHIN and all organizations involved in service provision to the addiction and concurrent disorders client populations to engage in evidence-based planning of addiction services. The scan produced data related to: service needs within communities; burden of illness related to addictions; addiction; collaboration and integration opportunities among addiction services, community and hospital based mental health providers and primary care practitioners (FHT, CHC, hospitals); and, identification of needed addiction services in CE LHIN. (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22e9a_72_206_94_2)

Emergency Department Avoidance Coalition - ongoing

- Shared resources and service coordination is a key component of delivering quality mental health and addictions services. The Emergency Department Avoidance Coalition was a new initiative that was formed using Pay for Results funding. The purpose was to create an integrated system of care for people with Mental Health and Addictions issues in Durham. Initial Coalition members included: Lakeridge Health, Durham Mental Health Services, CMHA Durham, Rouge Valley Health System, Durham Regional Police and Ontario Shores. One of the major successful outcomes of this Coalition was the implementation of a "new way of doing business" in Mental Health Service delivery that the Central East LHIN expects to be replicated throughout the Central East LHIN area.

Wellness Recovery Action Plan (WRAP) – ongoing

- WRAP is a specific education program aimed at building the capacity of people with mental health issues to manage their own health from a peer perspective. The CE Consumer Survivor Initiative (CSI) Network submitted a proposal to the CE LHIN to provide WRAP groups to the community. The CE LHIN provided funding that resulted in over 150 people with mental health issues completing training in the WRAP model. The WRAP self management tool has been shown to reduce Emergency room visits and improve overall health outcomes.

Early Intervention for Youth with Mental Health and/or Addiction Needs Priority Project – completed

- This project was identified as a significant need to deal with the current challenges in transitioning youth between adolescent mental health and adult mental health services. Unnecessary delays in early identification, treatment, continuous care planning and the "hand-off" of care from one provider to the next can be the result of service providers being unable to efficiently respond to transitioning. The Project Team researched existing strategies for prevention and health promotion and began to establish partnerships across the CE

LHIN to create "client journey maps" and standardized protocols related to youth transitioning into adult mental health and addictions services. (http://www.centraleastlhin.on.ca/Page.aspx?id=10256)

Disordered Eating Priority Project – completed

- The purpose of the Disordered Eating Priority Project was to implement education and awareness initiatives designed to enable the earliest possible identification and intervention by families and health care providers. Best practices and preferred models for transition between acute care and community settings were identified as well as best practices and models for on-going support for caregivers.
- The Disordered Eating Project wrapped up in February 2010, with a final presentation to the project team.. In addition to providing recommendations for continuing caregiver support, the project built capacity in the system related to disordered eating and provided the community with ongoing educational material through the website. (http://www.centraleastlhin.on.ca/Page.aspx?id=10414)

Acute Mental Health Separations, Days & Average Length of Stay (ALOS), Central East & Ontario Hospitals

Hospitals	Separations	Acute		Total	
		Days	ALOS	Days	ALOS
Durham					
Lakeridge Health-Bowmanville	48	186	3.9	253	5.3
Lakeridge Health-Oshawa‡	1,184	13,465	11.4	14,696	12.4
Lakeridge Health-Port Perry	31	234	7.5	418	13.5
Markham Stouffville-Uxbridge Site	32	183	5.7	183	5.7
Rouge Valley Health System-Ajax Site‡	645	6,763	10.5	7,652	11.9
Haliburton					
Haliburton Highlands Health Services-Haliburton	12	78	6.5	78	65
Kawartha Lakes					
Ross Memorial	116	1,175	10.1	1,392	12.0
Northumberland					
Campbellford Memorial	72	537	7.5	1,051	14.6
Northumberland Hills	98	503	5.1	668	6.8
Peterborough					
Peterborough Regional Health Centre‡	905	11,664	12.9	12,948	14.3
Toronto					
Rouge Valley Health System-Centenary‡	1,379	13,263	9.6	13,418	9.7
Scarborough Hospital-Grace Site‡	840	8,915	10.6	9,678	11.5
Scarborough Hospital-Scarborough General Site‡	1,028	8,022	7.8	8,932	8.7
Total Central East	**6,390**	**64,988**	**10.2**	**71,367**	**11.2**
Ontario	**57,683**	**621,495**	**10.8**	**696,049**	**12.1**

Source: Inpatient Discharges data, MOHLTC, Provincial Health Planning Database, 2004/05.
‡Mod-acute psychiatry beds as at March 31, 2005.

Community Engagement Activities

In 2009-10, the activities of the Central East LHIN continued to be supported by the commitment, knowledge and passion of hundreds of local individuals participating on our Planning Partnerships; self formed networks and Project Teams. A record of these activities can be seen by clicking on the Calendar page on the Central East LHIN website. (http://www.centraleastlhin.on.ca/showcalender.aspx?ekmensel=e2f22e9a_72_196_btnlink)

Planning and Engagement Collaboratives

A Collaborative is a local advisory team consisting of 9 to 15 people who provide and/or receive health care services in a specific community. Collectively, these teams approximate the continuum of the health care system with members from primary care, hospitals, community services, mental health and addiction services, long-term care, physicians, and pharmacists. Local residents interested in the public health care system also participate. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=576)

Zone 1 - Haliburton Highlands Collaborative
Zone 2 - Kawartha Lakes Collaborative
Zone 3 - Peterborough City and County Collaborative
Zone 4 - Northumberland/Havelock Collaborative
Zone 5 - Durham East Collaborative
Zone 6 - Durham West Collaborative
Zone 7 - Durham North/Central Collaborative
Zone 8 - Scarborough Agincourt Rouge Collaborative
Zone 9 - Scarborough Cliffs Centre Collaborative
Cross Zone - French Language Health Services (FLHS) Collaborative

In 2009/10, volunteers on the zone-based collaboratives participated in a process that will now lead to three cluster based collaboratives representing Scarborough, Durham Region and the Northeast which includes Northumberland, Havelock, Peterborough City and Country, Kawartha Lakes and Haliburton/Minden.

Francophone Initiatives

In May 2008, the Central East LHIN, in partnership with the Ministry's Regional Consultant for French Language Health Services (FLHS), established a FLHS Collaborative, an action identified in the Integrated Health Service Plan. Unlike the other collaboratives, which are geographically specific, the French Language Health Services Collaborative represents the entire French community in the Central East LHIN. Eight dedicated individuals, with cross-sectored experience in health care and community services, have joined this collaborative and are providing advice to the LHIN on the needs of francophone residents.

In 2009/10, the French Language Health Services (FLHS) Collaborative initiated a baseline survey for the Central East LHIN jointly with other GTA LHINs. This survey was shared with the Central East LHIN office for further exploration. The FLHS Collaborative participated in engagement sessions related to the development of the LHIN's second IHSP in 2009/10 and played an integral role in the development of the Culture, Diversity and Equity report for the Central East LHIN. The FLHS Collaborative will continue to play an advisory role to the Central East LHIN in 2010/11.

French-Speaking Population in Central East LHIN

Sub-LHIN Planning Zone	Population who include French as mother tongue – total responses	% of population who include French as mother tongue
Haliburton Highlands	265	1.7%
Kawartha Lakes	870	1.2%
Peterborough City and County	1,650	1.3%
Northumberland-Havelock	920	1.2%
Durham East	5,070	2.3%
Durham West	5,470	1.98%
Durham North/Central	555	1.1%
Scarborough /Agincourt-Rouge	2,250	0.8%
Scarborough Cliffs – Scarborough Centre	3,285	1.2%
Total	**20,360**	**1.4% of CE LHIN population**

Aboriginal Initiatives

The Central East LHIN is a diverse region that includes several First Nations: Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation and Mississaugas of Scugog Island First Nation. There are other Aboriginal peoples throughout the LHIN area including Métis and Inuit. The First Nation communities combine for a total of approximately 12,000 residents. In 2008/09, the Central East LHIN reached out to the local First Nations, Métis and off-reserve Aboriginal communities to identify opportunities for better communication and collaborative planning.

Building on discussions held in previous years and endorsed by Aboriginal representatives, the Central East LHIN began to develop the "Health Advisory Circle" in the first three months of 2009.

Renamed the Mnnamodzawin and LaSaantii Advisory Circle, the group held their first meeting on August 25, 2009 at the Mississaugas of Scugog Island in Port Perry. Supported by a Terms of Reference, the role of the Advisory Circle is to advise the Central East LHIN regarding the health care needs of First Nations, Non-Status, Metis and Inuit peoples residing in the LHIN

Again in 2009/10, the LHINs of the Greater Toronto Area (GTA) collaborated in planning an engagement event with the GTA Aboriginal community at the Native Canadian Centre of Toronto. Participants represented Aboriginal agencies and programs throughout the GTA – the LHINs and the community continued to connect based upon a shared vision of improving the health status of urban Aboriginal peoples.

Census Counts of Aboriginal Identity and Aboriginal Ancestry Populations – Central East LHIN, 2006

	Central East LHIN	Ontario
Total Aboriginal Identity Population	16,390	242,490
North American Indian single response	10,525	158,400
Metis single response	5,015	73,610
Inuit single response	210	2,035
Multiple Aboriginal response	100	1,905
Aboriginal responses not included elsewhere	600	6,540
Total Aboriginal Ancestry Population	34,515	403,795
Percent Population by Aboriginal Identity	1.2%	2.0%
Percent Population by Aboriginal Ancestry	2.4%	3.4%

LHIN-wide Networks

Like Collaboratives, Network membership represents the continuum of health care services. Unlike the Collaboratives, however, Networks bring together a single team from across the LHIN on a specific priority area identified in the IHSP. For the most part, Networks are the generative bodies for new strategic directions that will improve service integration and quality of care for their priority communities. Networks are guided by a steering committee of 12 to 15 individuals with specific interests and skills related to the priority. The steering committee acts as a conduit between the LHIN and the broader Network – which can also be defined as a community of interest. The broader Networks are not limited in their size.
(http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=632)

Seamless Care for Seniors Network
Chronic Disease Prevention and Management Network
Mental Health and Addiction Network

In November 2008, the Central East Hospice Palliative Care Network formed after members of the hospice palliative care sector within Central East embarked on a process to integrate the three predecessor End-of-Life Care Networks operating in Central East (Durham Region End-of-Life Care Network; Haliburton, Kawartha and Pine Ridge End-of-Life Care Network; and Toronto Palliative Care Network-East Region). A Planning Framework and Terms of Reference for the new network have been developed, as well as the identification of the inaugural Steering Committee. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=12934)

In addition, the LHIN participates in a self-formed Central East Diabetes Network. Comprised of diabetes educators and health service providers from across the LHIN, this large group shares best practice information and continues to support the LHIN on achieving Ministry objectives related to diabetes care.

In 2009/10, volunteers from the Network Steering Committees also participated in a process that resulted in the "closing out" of the three priority area networks and the establishment of two Strategic Aim Coalitions that will now focus on achieving the LHIN's Strategic Aims of saving 1,000,000 hours of time spent in the Emergency Department and reducing the impact of vascular disease.

Task Groups/Working Groups

Task groups are time-limited action teams established to address common issues or opportunities common to the Networks (i.e., priority areas) and Collaboratives. They consist of members with specific expertise related to the subject, and are drawn from all corners of the Central East LHIN. For example, the **Primary Care Working Group** consists of physicians, nurse practitioners and other allied health professionals that serves as a leading primary care resource on issues related to our health care priorities. These groups include:

Emergency Department Task Group
Alternate Level of Care Task Group
Rehabilitation Services Task Group
Primary Care Working Group
eHealth Steering Committee

In 2009/10, volunteers from the Task Groups also participated in a process that resulted in the "closing out" of some of the Task Groups and the establishment of the two Strategic Aim Coalitions that will now focus on achieving the LHIN's Strategic Aims of saving 1,000,000 hours of time spent in the Emergency Department and reducing the impact of vascular disease. Task Groups continuing forward into 2010/11 include the Primary Care Working Group and the eHealth Steering Committee.
(http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=634)

Health Professionals Advisory Committee (HPAC)

In 2008, the CE LHIN established a **Health Professionals Advisory Committee (HPAC)**. These new committees, which are now in place in each LHIN, are responsible for assisting the LHINs in carrying out their responsibilities by providing advice on how to achieve patient-centered health care. The fourteen (14) members of the CE LHIN HPAC include physicians, nurses and allied health professionals from across the LHIN. The group works directly with the Chief Executive Officer to review LHIN activities and offer advice.
(http://www.centraleastlhin.on.ca/Page.aspx?id=10178&ekmensel=e2f22c9a_72_184_10178_5)

Other Engagement Activities

In May 2009, the Central East LHIN hosted its third **Annual Symposium**: "Making a Difference." Planning partners, community residents and health care providers from across the entire region were invited to the two day event. The event provided an opportunity for the LHIN staff and board to introduce health service providers to the LHIN's strategic aims and seek their feedback in the development of the 2010-2013 IHSP.
(http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=13042)

In the early summer of 2009, LHIN staff attended a **Seniors' Summit** at the Evinrude Centre in Peterborough. This provided the LHIN with an opportunity to network with health care service providers and share information with local residents on the many services available to them in their local community.

Hospital leadership from across the Central East LHIN met with LHIN staff to begin work on the 2010/11 Hospital Service Accountability Agreement in June 2009. This type of **Sector Engagement** proved to be very successful for knowledge transfer and education and was duplicated with the Community Support Services sector and the Long-Term Care sector throughout 2009/10 supported through technology such as video conferences and webinars.

The **ED Avoidance Coalition** – which included representatives from Rouge Valley Health System, Lakeridge Health, Ontario Shores Centre for Mental Health Sciences, Durham Mental Health Services, United Survivors and Durham Regional Police – were supported to attend a number of knowledge transfer events in the summer of 2009 hosted by the Institute for Healthcare Improvement. These events allowed local health service providers to

network with colleagues from across Canada and around the world and share information on the improvements they were making in the delivery of mental health services in the Central East LHIN.

In 2009/10 the Central East LHIN began a dialogue with the region's five **Medical Officers of Health**. These bi-monthly meetings have provided a strong foundation for information sharing and partnership and were particularly effective during H1N1 preparedness. These meetings will continue in 2010/11 as the Public Health units participate in the implementation of the second IHSP.

H1N1 preparedness was also supported by the development and ongoing work of the **Central East LHIN System Surge Management Committee**. Led by the LHIN's Critical Care Lead and supported by Central East LHIN staff, this group of hospital, CCAC and primary care representatives spent time in 2009/10 developing a Moderate Surge Plan and shared best practices on system response to the flu and other potential pandemics.

In August 2009, over 1,000 Central East households were contacted when the LHIN launched a **telephone poll** to measure the public's current level of confidence in the health care system. Survey responses were incorporated into the 2010-2013 Central East LHIN Integrated Health Service Plan (IHSP) and reinforced the direction and information the LHIN had received from health care providers and members of its planning partner teams.

In the early winter of 2009 and again in the spring of 2010, the Central East LHIN Board of Directors met with their governance colleagues from Central East LHIN Health Service providers as part of a **Board to Board Engagement Strategy**. Three Board to Board Collaboratives – Scarborough, Durham, and Haliburton, Kawartha, Northumberland, Peterborough - north east region – were established with the goal of creating a culture of cooperation where each health service provider understands their contribution to the overall health system and its performance. It provided a forum for joint strategic planning and the identification of integration opportunities and the sharing of best practices and tools to raise the bar of health care governance.

Staff and Board members from the Central East LHIN continue to attend public meetings as part of the LHIN's **Speakers' Bureau** program to answer any questions about the Central East LHIN and provide information on how people can be involved in local health planning. This included presentations to a number of **local and regional government councils**. In October 2009, this also included a presentation by the CEO of the Central East LHIN to the **Association of Municipalities of Ontario – Counties, Regions and Single Tier and DSSAB conference**.

Engagement with physician leaders is also a priority activity for the Central East LHIN and in November 2009 staff attended the **GTA Primary Care Symposium** where family physicians from across the GTA benefitted from education sessions conducted by their specialist colleagues.

In February 2010, the Chair and CEO of the Central East LHIN, along with their other sister LHINs in the GTA, met with the **French Language Services Commissioner** to discuss French language health planning entities and potential partnerships with the LHINs.

Integration Activities

One of the main goals of each LHIN is the integration of health care services to create a more efficient health care system while at the same time improving the health care experience by creating a seamless system of care.

In 2009/10, the LHIN continued to support Voluntary Integration Planning through the following:

Health System Improvement Pre-Proposals (HSIP) – (www.centraleastlhin.on.ca**)**

- This process has been designed to reduce the time and costs Health Service Providers incur in preparing detailed business cases for additional funding. H-SIPs enable the LHIN to make a preliminary assessment of any request or activity contemplated by a Health Service Provider that requires the LHIN's approval. An online submission tool, created by staff in the Central East LHIN organization, was designed to streamline the application process.

CE LHIN Project Management Office – (http://www.centraleastlhin.on.ca/report_display.aspx?id=7804**)**

- The CE LHIN has adopted a project management philosophy and processes as Planning Partners and Health Service Providers develop and implement projects designed to enhance and strengthen health care delivery in the Central East region. The Virtual Project Management office (PMO) project was initiated in April 2008 and continues to provide Health Service Providers with web-based tools, external training coordination and one on one consultation and advice relating to the application of project management tools and processes, as well as voluntary integrations.

e-Health initiatives – (http://www.centraleastlhin.on.ca/Page.aspx?id=11808**)**

- e-Health or Electronic Health means using information and communication technologies to help meet the health care needs of people, health care professionals, health care providers, and policy makers. As an enabler, e-Health can enhance and support health service providers to better care for their patients. In 2009/10, the e-Health team, continued to work closely with the organizations in the Central East LHIN in implementing a strategy and roadmap to support the Integrated Health Service Plan (IHSP).

Integration accomplishments in 2009/10 included:

Hospital Clinical Services Plan - CSP

- Over 150 clinical stakeholders – doctors, nurses, allied health professionals, administrative leaders – participated in an extensive community engagement process to develop the CSP. A steering committee of over 20 health care leaders was established to oversee the project and a number of advisory groups were tasked with the responsibility of developing a hospital clinical services framework and bringing forward plans for the delivery of selected surgical and medical services where issues of quality and access were of greatest concern. Recommendations around cardiac, maternal-child-youth, mental health and addiction, thoracic surgery and vascular surgery services were put forward by the Steering Committee.
- Many of these recommendations have been implemented including funding to continue and expand the Rouge Valley Centenary Code STEMI (ST-segment elevation myocardial infarction) program which provides PCI (percutaneous coronary intervention) within 90 minutes of a patient presenting with symptoms allowing more lives to be saved. The Central East LHIN Board of Directors also endorsed the Peterborough Regional Health Centre's plan to establish a PCI / STEMI service and approved a Voluntary Integration of Lakeridge Health Corporation, The Scarborough Hospital and Rouge Valley Health System oncology surgical program in summer 2009.

Health Human Resources

- Ontario Shores Centre for Mental Health Sciences and Alzheimer Society Durham completed a voluntary integration in December 2009 to transfer the position of psychogeriatric consultant from the Alzheimer Society to Ontario Shores.

Back Office

- In January 2010, the Alzheimer Societies in Peterborough and Kawartha Lakes voluntarily integrated their organizations to create a single entity. Direct service delivery was enhanced as the agency created a single administrative structure and board governance.

Chronic Disease Prevention and Management

- Health service providers in Peterborough initiated a voluntary integration to streamline the management of vascular conditions. The **Comprehensive Vascular Disease Prevention and Management Initiative** involves Peterborough Regional Health Centre, the Peterborough Networked Family Health Teams, Primary Health Care Services of Peterborough, Peterborough Regional Nephrology Associates, Vascular Health Network, Astra Zeneca Canada and the Heart and Stroke Foundation of Ontario and is designed to develop and track comprehensive care pathways for the identification and management of vascular conditions.

Telestroke

- The Central East LHIN was one of four LHINs that partnered with the Cardiac Care Network and local hospitals to enhance the Provincial Telestroke Program. This facilitated integration now provides timely access for the Peterborough Regional Health Centre and Lakeridge Health Oshawa (both regional stroke centres in the Central East LHIN) with continued access to the Provincial Telestroke Network.

ER Wait Times Initiatives/ Improving the ALC Situation

Important to the health care system and to hospitals in the Central East LHIN is decreasing patient flow times for treating and discharging patients through CE LHIN emergency departments. Additionally, placement of patients classified as Alternate Level of Care (ALC) is a priority across the province and in the CE LHIN. ALC is a complex, serious system issue that impacts patient access to care, patient safety, and patient quality of life. It is costly to the health and well-being of the patient and their loved ones, and it is costly to the health care system.

With the support of health service providers across the Central East LHIN, the following initiatives were implemented in 2009/10 to address these government priorities:

Rouge Valley Health System

- Full service Ambulatory Care Areas in the Emergency Departments for CTAS III-IV patients were opened to improve patient flow and support additional physician coverage. Both sites of the Rouge Valley Health System improved their wait times, depending on the CTAS level. The ED Information System tracks patient flow and highlights a patient's progression through the department including completion of diagnostic tests, length of stay and flags patients at risk of exceeding their length of stay targets.

Ross Memorial Hospital

- A new Inpatient Admission Unit allowed the hospital to provide timely admission for emergency department patients to inpatient beds. The addition of a dedicated Nurse Practitioner and a Physician Assistant to the team in the ED provided additional support to the hospitalists and ED. Physicians covering the Emergency Department and participation in a LHIN-wide LEAN process provided information on streamlining processes that impact patient flow.

The Scarborough Hospital

- An Electronic Bed Board system integrated the activities of housekeeping, portering and bed allocation across the hospitals to improve communication and patient flow. Staff dedicated to Patient Relations and Navigation supported nursing staff in meeting with patients and their families to improve flow. A hands-free communication system linked to the hospital's wireless network improved staff communication in treating and discharging patients. Ongoing support for a Laboratory Technologist dedicated to the Emergency Department provided additional support to nursing staff and sped up patient flow.

Lakeridge Health

- A Rapid Assessment Urgent Care Clinic provided timely access to treatment for CTAS III-IV patients and helped to reduce wait times. Additional funding for Phlebotomist Coverage, an ED Unit Clerk, Hospital Portering and Patient Flow Co-ordination in the Emergency Department provided more support to nursing staff to increase direct patient care. A Corporate Flow Improvement Team, part of the learnings from the LHIN-wide LEAN process looked at improving admission and discharge processes in key clinical areas to enhance patient flow. And a focus on Bed Turn around Time resulted in first response tandem housekeeping teams to enhance the current service and improve patient flow.

Central East Community Care Access Centre

- Funding provided to the Central East CCAC allowed the agency to place dedicated Case Managers in the Rouge Valley Centenary Emergency Department. This pilot project was designed to expedite the referral process for patients being discharged from the Emergency Department and helped staff to identify which patients could benefit from CCAC services. This also allowed the Geriatric Emergency Management (GEM) nurse to focus on providing acute care for frail, elderly patients. NP (Nurse Practitioner) Outreach Teams were established throughout the Central East region to travel to long-term care homes. NPs provided care to residents who require less urgent or advanced interventions and assessments which in many cases prevented their transfer to the local Emergency Department or hospitalization.

Campbellford Memorial Hospital

- Campbellford Memorial Hospital led a LHIN-wide project to assess the need for a coordinated system for non-urgent transportation. This initiative aligns with the LHIN's Clinical Services Plan and will support six designated hospitals. (http://www.centraleastlhin.on.ca/uploadedFiles/Public_Community/Get_Involved/Sector_Engagement/LTC_PresentatiNon_Urgent_Transportation.pdf)

Partnerships with Community Agencies

- Ross Memorial Hospital in Lindsay, Community Care City of Kawartha Lakes and the Central East Community Care Access Centre partnered to deliver a Wrap Around Service to support discharged patients as they returned home. This voluntary integration was designed to improve ED wait times and ALC performance targets. A similar program was introduced in Northumberland County and involved Northumberland Hills Hospital, the CCAC and Community Care Northumberland.
- Durham Mental Health Services was funded to open 5 mental health crisis beds in the community. This partnership with Rouge Valley Health System resulted in a mobile crisis service that could respond to the Emergency Department and then see the patient transferring to a community-based service if more intervention was required.
- Lakeridge Health Corporation worked in partnership with Oakwood Retirement Communities and the Central East CCAC to provide a Transitional Care Unit in the Village of Taunton Mills. This unit was designed to relieve ALC pressures at Durham hospitals, and in its ten months of operation, saved 4600 ALC days at Lakeridge Health Bowmanville and Oshawa.

Peterborough Regional Health Centre (PRHC) ALC Assessment and Coaching Team

- The CE LHIN and PRHC jointly funded an ALC external review team comprised of experts from other hospitals in the CE LHIN, the CCAC, the Long-Term Care sector and the Regional Geriatric Program. The goal was to understand the ALC issues at PRHC and find ways to mitigate the problems and/or minimize the risk of recurrence. A final report, presented to the Central East LHIN Board in September 2009, provided a summary of findings of the ALC data, a synopsis of the main challenges faced by the hospital, and offered six recommendations that were expected to have the greatest impact on ALC. The report has provided a foundation of work from which PRHC, other CE LHIN hospitals and community agencies continue to reference in designing strategies and interventions to reduce the ALC burden.

ANALYSIS OF CE LHIN OPERATIONAL PERFORMANCE

In 2009-10 the CE LHIN received a total operating budget of $7 million which included operations at $4.7 million and additional funding of $2.3 million as noted in the financial statements (note 8). The additional funding for special projects allowed the LHIN to pursue initiatives such as Diabetes education, Aboriginal planning, evaluating and monitoring ER/ALC performance, e-health activities and support to the French Language Services community. The CE LHIN exercised prudent fiscal management to balance its internal operations budget and met the 1% objective target.

New directives for travel, meal and hospitality expenses and procurement as directed by the Ministry of Health and Long-Term Care were received. This required revised internal policies and procedures that were reviewed and approved by the audit committee of the board.

The final phase of the leasehold improvements ended with the opening of the new board meeting room and additional work spaces for the LHIN's e-Health, PMO and Health Force Ontario staff. The LHIN continues to work with the LHIN Shared Services Office (LSSO) which supports financial, human resources and information technology services.

Deloitte

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

AUDITORS' REPORT

To the Members of the Board of Directors of the Central East Local Health Integration Network.

We have audited the statement of financial position of the Central East Local Health Integration Network (the "LHIN") as at March 31, 2010 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Central East Local Health Integration Network as at March 31, 2010 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 7, 2010

Statement of Financial Position

year ended March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**536,038**	1,249,277
Due from Ministry of Health and Long Term Care ("MOHLTC")	**1,533,500**	1,485,300
Accounts receivable	**1,192,464**	6,187
	3,262,002	2,740,764
Liabilities		
Accounts payable and accrued liabilities	**1,423,365**	1,230,297
Due to Health Service Providers ("HSP")	**1,533,500**	1,485,300
Due to MOHLTC (Note 3b)	**354,269**	28,950
Due to the LHIN Shared Services Office (Note 4)	**-**	7,546
Deferred capital contributions (Note 5)	**369,310**	380,725
	3,680,444	3,132,818
Commitments (Note 6)		
Net debt	**(418,442)**	(392,054)
Non-financial assets		
Prepaid expenses	**49,132**	11,329
Capital assets (Note 7)	**369,310**	380,725
	418,442	392,054
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

Statement of Financial Activities

year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 Actual	2009 Actual
	$	$	$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	1,888,981,690	1,923,766,995	1,837,250,608
Operations of LHIN	4,702,230	4,452,752	4,329,312
Emergency Department ("ED") Lead (Note 10a)	-	75,000	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") (Note 10b)	-	100,000	33,300
Aboriginal Planning (Note 10c)	-	20,000	32,250
e-Health (Note 10d)	-	1,885,000	700,000
Diabetes Strategy	-	25,000	-
Self Management program	-	35,000	-
French Language Services	-	173,700	-
Aboriginal Health Transition Funding	-	51,000	-
Amortization of deferred capital contributions (Note 5)	-	260,893	209,814
	1,893,683,920	1,930,845,340	1,842,630,284
Expenses			
Transfer payments to HSPs (Note 9)	1,888,981,690	1,923,766,995	1,837,250,608
General and administrative (Note 11)	4,702,230	4,664,979	4,524,969
ED Lead (Note 10a)	-	75,000	75,000
ER/ALC (Note 10b)	-	100,000	33,300
Aboriginal Planning (Note 10c)	-	20,000	32,015
e-Health (Note 10d)	-	1,707,447	685,442
Diabetes Strategy	-	25,000	-
Self Management program	-	35,000	-
French Language Services	-	73,700	-
Aboriginal Health Transition Funding	-	51,000	-
Resident's First program	-	900	-
	1,893,683,920	1,930,520,021	1,842,601,334
Annual surplus before funding repayable to the MOHLTC	-	325,319	28,950
Funding repayable to the MOHLTC (Note 3a)		(325,319)	(28,950)
Annual surplus	-	-	-
Opening accumulated surplus			-
Closing accumulated surplus	-	-	-

Statement of Changes in Net Debt

year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010	2009
		$	$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	**(249,478)**	(280,717)
Amortization of tangible capital assets	-	**260,893**	209,814
Change in other non-financial assets	-	**(37,803)**	3,542
Increase in net debt		**(26,388)**	(67,361)
Opening net debt	-	**(392,054)**	(324,693)
Closing net debt	-	**(418,442)**	(392,054)

Statement of Cash Flows

year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**260,893**	209,814
Amortization of deferred capital contributions (Note 5)	**(260,893)**	(209,814)
	-	-
Changes in non-cash operating items		
(Increase) decrease in due from MOHLTC	**(48,200)**	5,527,810
Increase in accounts receivable	**(1,186,277)**	(6,187)
Increase in accounts payable and accrued liabilities	**193,068**	487,872
Increase (decrease) in due to HSPs	**48,200**	(5,527,810)
Increase (decrease) in due to the MOHLTC	**325,319**	(840,165)
(Increase) decrease in prepaid expenditures	**(37,803)**	3,542
Decrease (increase) in due to the LHIN Shared Services Office	**(7,546)**	5,702
	(713,239)	(349,236)
Capital investments		
Acquisition of tangible capital assets	**(249,478)**	(280,717)
Financing transactions		
Capital contributions received (Note 5)	**249,478**	280,717
Net decrease in cash	**(713,239)**	(349,236)
Cash, beginning of year	**1,249,277**	1,598,513
Cash, end of year	**536,038**	1,249,277

Notes to Financial Statements

1. Description of business

The Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park. The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable, expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any excess of funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

3. Funding repayable to the MOHLTC (continued)

	Revenue	Expenses	2010 Surplus	2010	2009 Surplus
	$	$	$	%	$
Transfer payments to HSPs	1,923,766,995	1,923,766,995	-		-
LHIN operations	4,713,645	4,664,979	48,666	1%	14,157
Aging at Home	-	-	-		-
ER/ALC	100,000	100,000	-		-
ED/Lead	75,000	75,000	-		-
Diabetes	25,000	25,000	-		-
E-Health	1,885,000	1,707,447	177,553	9%	14,558
Aboriginal Planning	20,000	20,000	-		235
French Language Services	173,700	73,700	100,000	58%	-
Aboriginal Health Transition Funding	51,000	51,000	-		-
Resident's First	-	900	(900)	-	-
Self Management	35,000	35,000	-		-
	1,930,845,340	1,930,520,021	325,319	-	28,950

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2010	2009
	$	$
Due to MOHLTC, beginning of year	28,950	869,115
Recovery by MOHLTC during the year	-	(869,115)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	325,319	28,950
Due to MOHLTC, end of year	354,269	28,950

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	380,725	309,822
Capital contributions received during the year	249,478	280,717
Amortization for the year	(260,893)	(209,814)
Balance, end of year	369,310	380,725

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2011	238,373
2012	238,373
2013	236,537
2014	232,949
2015	228,331
Thereafter	133,193
	1,307,756

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs based on the current accountability agreements are as follows:

	$
2011	1,896,186,889
2012	1,896,186,889

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2010 Net book value	2009 Net book value
	$	$	$	$
Office furniture and fixtures	424,509	324,477	100,032	184,932
Computer equipment	182,627	136,317	46,310	30,573
Web development	36,100	36,100	-	7,593
Leasehold improvements	658,898	435,930	222,968	157,627
	1,302,134	932,824	369,310	380,725

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,923,766,995 is made up of the following:

	$
Initial HSP funding budget	1,888,981,690
Adjustment due to announcements made during the year	34,785,305
Total HSP funding budget	1,923,766,995

8. Budget figures (continued)

The total revised operating budget of $7,066,930 is made up of the following:

	$
Initial budget as represented on the statement of financial activities	4,702,230
Additional funding received during the year for:	
ER/ALC	100,000
ED/Lead	75,000
Diabetes	25,000
E-Health	1,885,000
Aboriginal Planning	20,000
French Language Services	173,700
Aboriginal Health Transition Funding	51,000
Self Management	35,000
Total budget	7,066,930

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,923,766,995 (2009 - $1,837,250,608) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2010 as follows:

	2010	2009
	$	$
Operation of hospitals	1,124,792,403	1,082,886,094
Grants to compensate for municipal taxation - public hospitals	294,975	294,975
Long term care homes	368,756,047	356,028,894
Community care access centres	208,746,653	195,064,667
Community support services	28,341,071	27,254,697
Assisted living services in supportive housing	13,024,039	11,996,510
Community health centres	20,015,681	12,267,412
Community mental health addictions program	52,902,577	50,100,532
Specialty psychiatric hospitals	105,624,200	100,271,165
Acquired brain injury	1,245,349	1,061,662
Grants to compensate for municipal taxation - psychiatric hospitals	24,000	24,000
	1,923,766,995	1,837,250,608

10. a) ED Lead

The LHIN received funding of $75,000 (2009 - $75,000) related to the ED Lead project. ED Lead expenses incurred during the year are as follows:

10. ED Lead (continued)

	2010	2009
	$	$
Consulting services	63,866	62,068
Salaries and benefits	-	11,086
Other	11,134	1,846
	75,000	75,000

b) ER/ALC

The LHIN received funding of $100,000 (2009 - $33,300) related to the ER/ALC project. ER/ALC expenses incurred during the year consist of $91,983 (2009 - $33,300) of salaries & benefits and $8,017 (2009 - $nil) of other expenses.

c) Aboriginal Planning

The LHIN received funding of $20,000 (2009 - $32,250) related to the Aboriginal Planning project. Aboriginal Planning project expenses incurred during the year consist of $nil (2009 - $31,250) of consulting fees and $20,000 (2009 - $765) of other expenses.

d) E-Health

The LHIN received funding of $1,885,000 (2009 - $700,000) related to the E-Health project. E-Health project expenses incurred during the year are as follows:

	2010	2009
	$	$
Consulting services	1,192,071	458,373
Salaries and benefits	261,421	156,903
Meetings	65,673	68,529
Supplies and other	188,282	1,637
	1,707,447	685,442

11. General and administrative expenses

The Statement of financial activities presents the expenses by function, the following classifies these same expenses by object:

	2010	2009
	$	$
Salaries and benefits	3,212,777	2,672,304
Occupancy	212,745	312,792
Amortization	260,893	209,814
Shared services	378,919	300,000
Community engagement	153,588	128,329
Consulting services	113,457	320,734
Supplies	118,424	137,970
Board member expenses	107,901	249,584
Mail, courier and telecommunications	3,154	5,007
Other	103,121	188,435
	4,664,979	4,524,969

11. General and administrative expenses (continued)

Note:

	2010 Budget	2010	2009
	$	$	$
Board chair per diem expense	50,000	50,750	36,575
Other board members per diem expense	100,000	50,279	129,792
CRA accrual historical expense	-	(30,463)	-
Governance costs and travel	70,000	37,335	83,217
Total expenses	220,000	107,901	249,584

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 28 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2010 was $251,562 (2009 - $202,595) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation of the plan was completed for the plan as of December 31, 2009. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

STAFF MEMBERS

Back Row

Amanda English, Karol Eskedjian, Emily Van de Klippe, Nancy Hunter, Jina Mintsinikas, Karen Ouellette, Janet Boland, Maria Grant, Kate Reed, Karen Landriault, Viola Zhou, Jai Mills

Middle Row

Carolyn Kanhai, Elizabeth Salvaterra, Jennifer Russell, Paul Barker, Deborah Hammons, James Meloche, Linda Henry, Suzette Stines-Walford, Karen O'Brien

Front Row

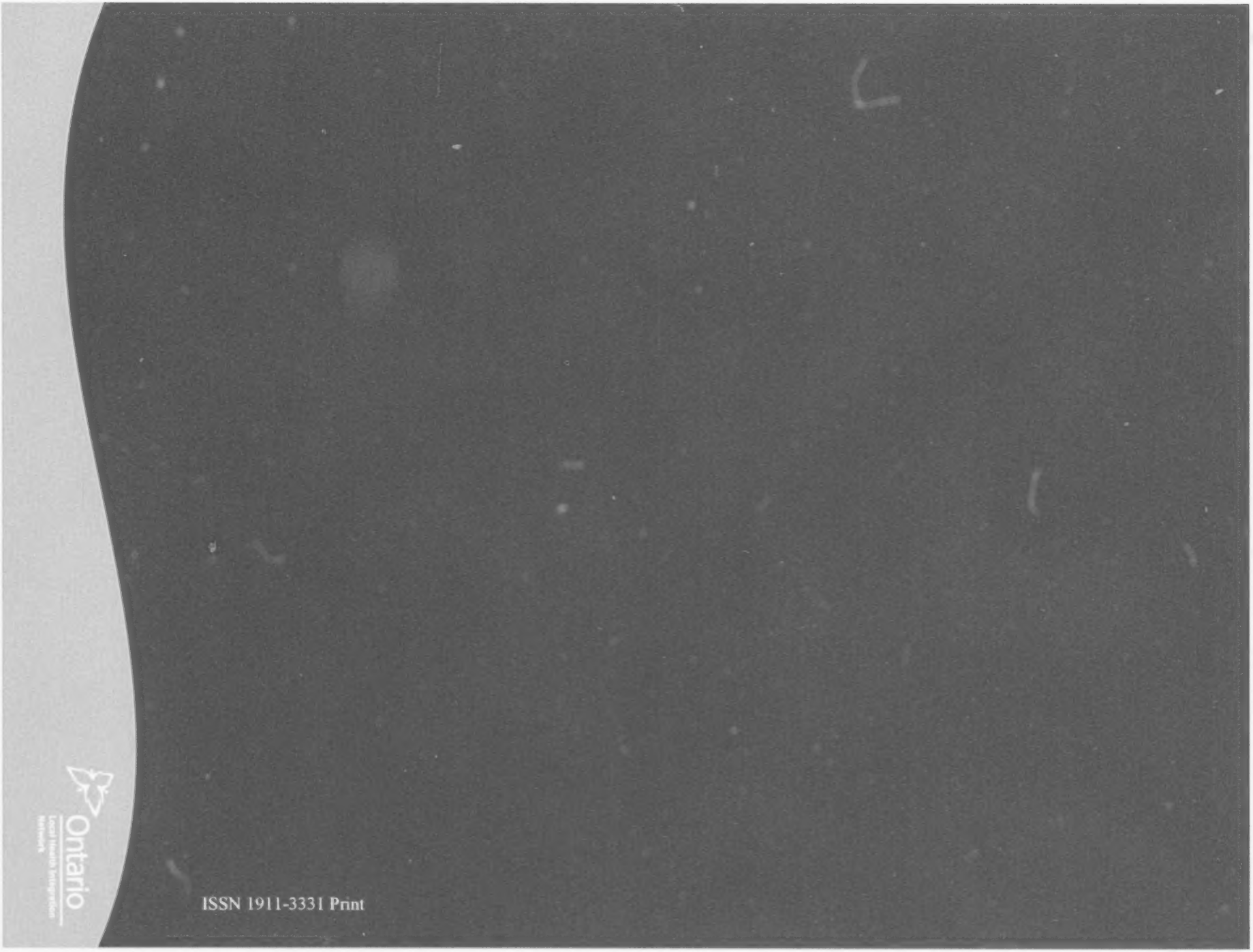
Katie Cronin-Wood, Brian Laundry, Sheila Rogoski, Lewis Hooper, Ritva Gallant, Jeanne Thomas, Jenny Greensmith

Absent

Claire McConnell, Ajay Thusoo, Marco Aguila, Tapas Kar, Christine Laity, Marlene Ross, Charli Law, Brittany Peterson, Lindsay Wyers

CONTACT INFORMATION

Telephone	905-427-5497 1-866-804-5446
Fax	905-427-9659
Address	Harwood Plaza 314 Harwood Avenue South, Suite 204A Ajax, ON L1S 2J1
Email	centraleast@lhins.on.ca
Website	www.centraleastlhin.on.ca



ISSN 1911-3331 Print